THE UNIVERSITY OF CHICAGO | Finance and Administration Division
Office of Risk Management

Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my medical, behavioral, and mental health information (also known as protected health information (PHI)) as described below.

1. I, _____, authorize all persons or entities who provided medical treatment to me to disclose the all medical information in your possession to PMA, its employees, agents, subcontractors and authorized representatives ("PMA") as specified below.

2. Please provide PMA with any and all information in your possession concerning my physical condition, past, present and future, including, but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other PHI/medical information so that PMA may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on __/__ /20__. I understand that the PHI/medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. This authorization shall be in force and effect until my claim related to injuries I received on __/__ /20__ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying Risk Management (WCclaim@uchicago.edu) OR PMA Customer Service Center, PO Box 5231, Janesville, WI 53547-5231, in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by PMA or the Releasing Party in reliance on it before I revoked it.

4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to PMA to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

5. A copy of this authorization may be accepted with the same authority as the original.

6. I understand I have a right to receive a copy of this authorization form after I sign it.

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Print Name of Patient or Personal Representative | Personal Representative's Authority

_____ _____
Witness Name | Witness Signature